Testimony of

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Good Morning,

Chairman Deal and members of the Committee, my name is Oren Harden and I am a pharmacist from Georgia. Thank you for allowing me the opportunity to relate some of the positive impact of the Medicare Modernization Act of 2003 (MMA) Part D and to voice some of the concerns that patients and pharmacists have expressed to me.

I have been privileged to practice pharmacy in a variety of settings including community chain and independent, hospital, long term care and military. For twenty six years I owned and operated two independent pharmacies in Albany, Georgia and Sylvester, Georgia. Currently I serve as the CEO of the Georgia Pharmacy Association.

I have a personal interest in Part D in that I am currently a beneficiary of Medicare Part A and D. I have a patient interest in that I have worked with dozens of family, friends and neighbors to enroll in Part D. I have a professional interest in that I represent some 2500 Georgia pharmacists who have made heroic efforts and personal and business sacrifices to see that Medicare Part D accomplishes its purpose in the healthcare of beneficiaries, their patients.

I believe that Part D of the MMA has had a positive impact on the healthcare of Medicare beneficiaries. People who were unable to afford medications prior to the passage of the MMA Part D can now afford those medications. I also believe that the Centers for Medicare and Medicaid Services (CMS) has done an outstanding job of implementing a very difficult program to manage. With changes that some House members are currently proposing MMA Part D can become significantly more effective both in quality of healthcare and cost effectiveness.

That being said, I would like to share with you some concerns of pharmacists and patients about the current structure of Part D and make suggestions that I feel would improve the program for the patient, the pharmacist and CMS management.

For the patient the number of plans should be reduced. There are far too many plans that are too similar in benefit design and that only serves to confuse the patient. There are 43 different Prescription Drug Plans (PDPs) available in Georgia in addition to the Medicare Advantage Plans (MAPDs). The web based tools available from CMS are very good but most Medicare beneficiaries are unable to properly utilize those tools. They are forced in most cases to consult with insurance agents or other non-healthcare professionals who are not aware of the specific therapeutic needs of the patient and how to best create a medication management plan in one of the PDPs. I believe the pharmacist whom the patient trusts and who is most knowledgeable of the patient's formulary needs should be given the authority to work with the patient to navigate the plethora of plans and advise the patient on how to make a choice based on the patients medication needs and choice of provider. Issues such as formularies, tiering, utilization management, differential co-pays, varying deductibles, co-insurance, "donut holes" and differences in grievances and appeals are simply too complex to be made understandable to the layperson and therefore limit the help available from friends and family.

It would be very beneficial in that respect if CMS were given the authority to offer and administer a single dependable, defined benefit plan which could combine the purchasing power of over 40 million Medicare beneficiaries with that of the VA. This would provide greatly reduced product cost allowing CMS to more effectively utilize funds for pharmacist management of medication therapy. Why is pharmacist management of medication therapy plans so important? Validated studies have been published that illustrate we spend as much of our healthcare dollar in correcting "medication misadventures" or drug reactions and interactions as we do on drugs themselves. To provide proper outcomes patients must have access to the pharmacist's clinical expertise. Under the current commercial plans there is no such provision at this time. A pharmacy benefit is not a drug product alone at the cheapest price as most PDPs or PBMs would have you think. Without the clinical knowledge and guidance of the pharmacist the drug product can do more harm than good to patient care while dramatically increasing the cost of healthcare.

Although the MMA provides for medication therapy management (MTM) in Part D, there is a disincentive to PDPs to offer proper management. The disincentive being that the major indicator of PDP performance is measured in the reduced cost of drug product not quality of outcomes. Many PDPs will opt to offer MTM via telephonic or electronic means using individuals other than the drug expert, the pharmacist. This is far less effective for quality outcomes improvement than face to face interaction between the patient and the pharmacist in constructing and managing a medication therapy plan. Medication Therapy Management should be defined by CMS, patients identified by the pharmacist and management performed by the pharmacist. Currently MTM is defined by each PDP differently and may be performed by "others" as stated in the MMA.

The Georgia Pharmacy Foundation (GPhF) working with the American Pharmacists Association and major pharmaceutical manufacturers has implemented a medication therapy management patient education model with several industries in our state to prove the increased quality of patient outcomes and the cost effectiveness of pharmacist directed MTM. One such project with a three year track record has data that illustrates that over the first two years of the MTM program, the overall annual healthcare cost for diabetic patients was lowered by 41% over the projected cost for those two years. The 41% per patient savings was in current hard dollar costs. Clinical indicators illustrate that future savings will be even more significant by virtue of the prevention of the complications of diabetes. In addition the absenteeism for the managed diabetic was reduced to almost zero and the workers compensation claims were reduced to absolute zero. The quality of life of these patients was so improved that production also increased. To accomplish improvement in quality of outcomes and reduction in overall healthcare expenditures the cost of physician's visits, pharmacist's medication therapy management and the expenditure on pharmaceuticals may increase in order to produce a savings in an individuals total healthcare costs. This local industry was so impressed by the significant improvement in the quality of life of their employees and the healthcare cost savings that GPhF is beginning implementation this week of the same type of pharmacist directed

MTM with hypertensive patients at that plant. GPhF is four months into this type of program with five other employers. The structure of MMA Part D, while authorizing MTM, has the disincentive I mentioned to the utilization of this approach to medication therapy management.

Currently the Georgia Pharmacy Foundation (GPhF) and the Georgia Medical Care Foundation (GMCF), Georgia's Quality Improvement Organization (QIO) are structuring a pharmacy quality improvement pilot project in Georgia in partnership with CMS. The purpose of this pilot is to document the healthcare quality improvement and cost effectiveness of the previously mentioned method of MTM in the Medicare population. We are certain that this pilot will illustrate the benefits to be gained in funding intensive MTM performed by a pharmacist not only to dramatically improve quality of care and augment positive outcomes but also to produce significant savings in healthcare expenditures.

Far too many plans did not at implementation and still do not have the support services to efficiently serve the patient and/or the pharmacist. Many are more interested in selling than in servicing. I am aware of and have reported to CMS plans that are contacting physicians without the patient's knowledge to gain access to protected health information in order to send medications by mail order. CMS has been very responsive to take corrective action when abuses are reported. Another marketing issue that has confused many patients is co-branding. My Part D ID card has the names of only six major chains on the card itself. Many patients have assumed that they must use only those pharmacies printed on the card thereby increasing the patient's confusion and decreasing their choice.

Form letters sent to patients who have applied for Part D can also be confusing. I received a form letter from the company with whom I applied that informed me of a potential for delay in obtaining confirmation of my enrollment. The letter stated "Information we have received indicates one of the following conditions may apply to your application which would make you ineligible". The two situations listed were that (1) you are not enrolled in Medicare Part B and/or you are not entitled to Medicare under Part A and (2) you have End State Renal Disease (ERSD) or you have had a kidney transplant and still require a regular course of dialysis. First of all if I was not very familiar with Medicare and Part A, B and D, I would be very concerned that I was not eligible for Part D on statement number one. Secondly, if I was not a healthcare professional, I would be terrified that I might have End State Renal Disease (ERSD, whatever that was). Of course I would surely know that I had not had a kidney transplant and did not require dialysis. I called the 800 customer number during the 8 am to 6 pm time frame twice and the first time after navigating an extensive menu of options received a recording that due to the popularity of their plan and high call volume no customer service representatives (CSRs) are available at this time. Upon eventually reaching customer service representative Jason on May 18th, I requested information as to why the delay. I was told that if I did not have both Part A and B I was not eligible for Part D. The most interesting part of this scenario is that I received my card the same day as I received the letter concerning the "problem" and was told by Jason ten days later when I reached customer service that I was enrolled. This on the same call in which he informed

me that I was not eligible for Part D unless I had both Part A and Part B. In addition to not having sufficient CSRs this plan does not have adequately trained CSRs. This plan has one of the highest enrollments nationwide.

From the pharmacist's perspective, the main issues in implementation were inadequate provider service and customer service from PDPs, too little compensation for services and long delays in the payment for medications. Many of the pharmacists that I represent borrowed substantial sums to be able to continue to provide service for their patients. In rural Georgia, had they not been willing to shoulder the financial burden, access for the patient would have been severely restricted. In order to make Part D successful, pharmacists devoted the extra time, worked through cash flow problems and met patient's needs when there was no guarantee that they would be compensated. Their efforts were recognized by HHS Secretary Leavitt and I quote "The efforts of pharmacists over the last month have been nothing short of heroic. I've visited with and heard from pharmacists all over the country. They have been selfless, compassionate and committed to service".

Bi-Partisan Legislation has been authored in both the House and Senate at this time that addresses many of the issues important to both the patient and pharmacist. The House Bill H.R. 5182 allows for prompt payment of pharmacy claims. In regards to MTM, H.R. 5182 requires HHS/CMS to define a minimum package of services a plan must provide, allows healthcare providers to identify patients who should receive MTM and requires plans to pay pharmacists and other providers based on the time and intensity of services. Other provisions on MTM assure access to services and establish a Best Practices Commission that would ensure a model that would allow for quality outcomes. H.R. 5182 also provides access to all pharmacists by eliminating branding on Medicare ID cards. This is a giant step toward solving the issues that I have discussed and improving the Part D program for patients and for pharmacists and for Medicare. I applaud the members of the House for this insightful approach to correcting issues that were detrimental to Medicare Part D. At the time of this writing H.R. 5182 has 38 Republican and 24 Democratic co-sponsors. I would like to thank Representatives Sherrod Brown and Tom Allen of this Committee for their co-sponsorship of this legislation. The Senate Bill addressing these issues is S. 2664.

I would like to add a final comment on a related issue before Congress at this time. If the concerns that are being addressed in Medicare Part D are also addressed prior to the implementation of the drug cost provisions affecting Medicaid in the Deficit Reduction Act of 2005, then quality of care and cost effectiveness will result immediately upon implementation of that legislation. A pharmacy benefit cannot be viewed as a drug product alone but must also include provision of the pharmacist's clinical services to ensure the proper utilization of a drug product to avoid costly complications associated with drug therapy and to provide for positive outcomes.

Thank you for the opportunity to share my thoughts how to make Medicare Part D more patient friendly, more cost effective and most importantly more focused on positive patient outcomes and quality of care.